

**State of Kansas  
Department of Social and Rehabilitation Services  
Disability and Behavioral Health Services  
Community Supports & Services**

**Community Living Choices**



**2009**

## **TABLE OF CONTENTS**

<b>I.</b>	<b>Introduction (New Millennium: Opportunities of Choice).....</b>
<b>II.</b>	<b>Referral Process/ Choosing a CSP &amp; Targeted Case Manager .....</b>
<b>III.</b>	<b>Role of the Targeted Case Manager.....</b>
<b>IV.</b>	<b>Developing a Person Centered Support Plan.....</b>
<b>V.</b>	<b>Transition Process.....</b>
<b>VI.</b>	<b>Ongoing Monitoring and Review.....</b>

## **APPENDICES**

<b>I.</b>	<b>Definitions.....</b>
<b>II.</b>	<b>Resource List &amp; Links.....</b>

**Statement of Purpose:**

This manual is published to provide a model for best practices in successful transition of persons into the community from institutional settings.

**Web Address:**

This manual will be published at the following web address:

<http://www.srskansas.org/hcp/css/DDInfo.htm>

**Review/Corrections:**

This handbook will be reviewed/revised by a subgroup of the ICF/MR work group, to keep the information current and accurate. These corrections will be communicated to all stakeholders via the CSS web site: <http://www.srskansas.org/hcp/cssindex.htm>

**Duplication:**

This handbook may be downloaded and duplicated within your agency to supply copies to staff/agencies arranging community services for persons in institutional settings and their families.

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# Introduction

## New Millennium: Opportunities of Choice



## Section I. Introduction

### *A New Millennium: Opportunities of Choice*

The quality and diversity of life for persons with developmental disabilities living in Kansas, continues to be effectuated by the organizational/political culture of inclusion and integration of persons with developmental disabilities into their own neighborhoods and communities. This movement gets its energy and momentum from progressive changes in social policy, state and federal legislation, and a Medicaid Home and Community Based Services waiver for persons with Mental Retardation or who are otherwise Developmentally Disabled (HCBS/MRDD waiver) program that funds opportunities to move out of institutions and into communities.

The most influential impetus to the philosophical shift in the developmental disabilities service delivery system came from the Kansas 1995 legislative session; the enactment of the [Kansas Developmental Disabilities Reform Act](#). In 1999, the U.S. Supreme Court decision in [Olmstead v. L.C.](#), advanced the cause further when that decision reaffirmed the applicability of the [Americans with Disabilities Act](#) (ADA) and clarified “that states must, to the extent that they are financially able, serve people with disabilities in the most integrated setting appropriate to their needs.”

The most recent history of services to persons with developmental disabilities in Kansas can be illustrated by numbers:

- In 1991, approximately 1,000 persons were being served in the three state mental Retardation hospitals (SMRHs), and about the same number were being served in Private Intermediate Care Facilities for the Mentally Retarded (ICFs/MR);
- In 1991, 1,700 persons were being served in a variety of HCBS/MRDD waiver-funded community residential settings. In May 2002, that number was 8,625 persons, and in January 2009, that number is 7300 persons.
- In May 2002, 376 persons were being served in two SMRHs, and 371 persons are being in 32 Private ICFs/MR;
- In January 2009 census indicate 375 persons being served in the SMRHs, and 180 persons were being served in the private ICF's/MR;
- In January 2009, Kansas has 28 private ICF's/MR (4 of those medium, 24 small) and two SMRH's;

Since 1991, the year Norton State Hospital was closed, the State of Kansas has overseen the closure, of 108 bed state institution, Winfield State Hospital, in 1998 and twenty- two private ICFs/MR. In 2008, Kansas provided oversight for the downsizing of 3 medium size private ICF's/MR to six small ICF's/MR and gave guidance in the closure of a medium size private ICF/MR and it's last remaining large private ICF/MR.

The Community Integration Project (CIP) handbook was written in March 1994, with the stated intent to “help you focus your thinking as you plan to serve persons with MRDD, who are transferring from institutional to community living . . . and work toward our common vision and change our system of services one person at a time.” The vision was for Kansas citizens to “live, work, play and learn in natural, inclusive settings, to direct their individual plan, be supported in the context of family and friends and receive respect for their lifestyle and culture.”

In 2002, that vision has expanded to include individual choice, the actualization of a preferred lifestyle, and increased independence and productivity as well as inclusion, and integration. In order to realize this vision, [Social and Rehabilitation Services, Division of Disability and Behavioral Health Services/Community Supports and Services](#) (SRS/DBHS/CSS) is committed to promoting and protecting the independence, empowerment and equal rights of people with disabilities, to expect and support “best practices” and to ensure that a person with developmental disabilities is fully and richly woven into a community’s fabric.

In 2008, the Money Follows the Person Demonstration Project provided an additional opportunity to ensure that all Kansans have the opportunity to live and work in settings of their choice, and for consumers/stakeholders to partner with the state agencies to ensure that Kansans with disabilities, have access to services in the community, as established under the Developmental Disability Reform Act (DDRA); Services where individuals can live healthy lives, free from all forms of mistreatment and with access to a qualified, well trained, and supported community workforce.

#### History:

Kansas first implemented a state Money Follows the Person Project in SFY04 in response to a legislative proviso in the States appropriation bill. One of the barriers to transitioning more individuals is the lack of funding for start up costs when someone returns to the community. MFP demonstration project via the addition of a demonstration service titled “transition service”. We are pleased that the MFP project will allow us to serve a large number of individuals from Public and/or Private ICF’s/MR. Kansas utilizes feral money follows the person for all persons served in the State operated ICFs/MR by statute and in practice. The Community Integration Project (CIP) has expanded from the original scope to include all persons living in private ICFs/MR that are closing beds.

Kansans with developmental disabilities and their support networks will direct the planning process, which will respect their unique lifestyles and cultures. Consumers of services have the right to have their options fully explained so that they and their representatives can make informed choices regarding where and how they will realize their preferred lifestyle. SRS/DBHS/CSS will collaborate, encourage and support consumers, families, Community Developmental Disability Organizations (CDDOs) and Community Service Providers (CSPs) in fulfilling their shared responsibilities so that every Kansan has the opportunity to choose what their life will look like.

The handbook is being rewritten to more accurately reflect the changes in the way services are being delivered to Kansas’ citizens with developmental disabilities, and to capture the systems

rich complexity and nuance and to help people navigate through it, without sacrificing the integrity, individuality and uniqueness of the persons for whom this system was designed to serve.

### The Developmental Disabilities Reform Act

The Developmental Disabilities Reform Act (DD Reform Act) was enacted in 1995 and went into effect in 1996. It caused many changes in the lives of people with developmental disabilities in Kansas by making individual choice the driving force behind service delivery.

The two key elements in the DD Reform Act are: single point of entry and person centered support planning process. Prior to the DD Reform Act, there were scattered Community Mental Retardation Centers (CMRC) throughout the state. If a person needed services, they and their family had to make do with what was available at any given time and in any given place. Some areas of the state lacked services, and in others, the choice of what services could be received were limited. As such, individuals who needed unique or individualized supports to live in the community were unable to find appropriate services and had no choice but to remain in institutions. The DD Reform Act, by creating single points of entry in DD services called Community Developmental Disabilities Organizations (CDDOs) created a process that individuals and families could use to access uniform services statewide. Every county in the state was assigned to a regional CDDO area, which meant that families had one place they would go to be determined eligible for services, receive information about services, and one organization to help choose those services. CDDOs also have a role in capacity building, developing new types of community services, driving quality assurance, and ensuring these services meet the individual's needs, both of which improve the ability of individuals coming out of institutional settings to succeed in the community.

In addition to single point of entry, the DD Reform Act also mandated Person Centered Support Planning. The Person Centered Support Planning process gives the individual and his/her family the tools to design a preferred lifestyle in the community. The Person Centered Support Plan drives all service delivery and makes it possible to build service and support plans unique to the person. It also gives the family and quality assurance personnel the tools to monitor the effectiveness of those services and ensures the individual continued success in the community. In the Person Centered Support Plan, the person being served and a support team work together to determine a person's lifestyle preferences and what supports need to be put in place for that to happen. For persons leaving an institutional setting, person centered support planning process can make it possible for a variety of support systems to be created in the community. The Person Centered Support Plan also gives people with developmental disabilities and their families a legal right to self-advocacy and empowers them to drive the quality of the service delivery system.

## Referral Process and Choosing your services





## **Section II. Referral Process, Choosing Your Service Provider & Targeted Case Manager (TCM)**

### ***Referral Process***

#### **A. Who Can Refer**

Persons living in SMRHs or ICFs/MR may be referred for community living from several sources. Those sources include, but are not limited to, the state mental retardation hospital, private ICF's/MR or the parents or guardians of these persons. The most common referral is from the team at the hospital or the ICF/MR. Those teams consider community services at their annual meetings or gate keeping reviews however, any individual may request a referral at anytime.

##### **1. State Mental Retardation Hospital or Private ICF's/MR**

Once a referral for community living is requested, the contact person will initiate the referral process by contacting the CDDO of choice or the home county CDDO for the person residing in the facility. The contact person at the hospital or ICF/MR will have a release of information signed by the guardian or person residing in the facility if they are their own guardian. This release will be forwarded to the appropriate CDDO representative who handles new referrals. Additional information such as the annual plan, PCSP, eligibility records, BASIS (Basic Assessment Service Information System), including scores and tier level and any positive behavior support plan and current data, are released with the referral to the CDDO.

The CDDO must respond within 120 days to the referral by following their approved referral process. The CDDO is responsible for sending the referral to the Community Service Provider (CSP) of choice. The CDDO is also responsible for working actively with the team to ensure that the full range of choices and options within the community of choice is communicated to the individuals. The CDDO must also work with the team, (individual & his/her guardian) and the chosen CSP to ensure that a smooth transition occurs and that all records and funding processes are put in place in a timely manner.

##### **2. Person or Guardians Initiate the Referral**

The person, his/her parents or guardian may request a referral for community services by either reporting this to the hospital or ICF/MR team or, by going directly to the area CDDO to initiate the referral. Generally, parents make this request to the social worker or **social service designee** at the facility where the person resides. The request will prompt immediate referral to the appropriate CDDO area.

###### **a. Person or guardians request that a referral be made by the hospital or ICF/MR team.**

The social worker or social service designee at the hospital or ICF/MR must have a release signed by the guardian or person residing in the facility if they are their own guardian. This release will be forwarded to the appropriate CDDO representative who handles new referrals. Additional information such as the annual plan, eligibility records, BASIS,

including score, tier level and any positive behavior support plan and current data, are released with the referral to the CDDO. The CDDO will immediately respond to the referral by following their approved referral process.

- b. Person or guardians make the referral directly to the CDDO. The CDDO will immediately respond to the referral by following their approved referral process. The CDDO is responsible for forwarding the referral to the community service provider of choice. Part of this process must include a release signed by the guardian or person residing in the facility if they are their own guardian. The CDDO will forward a copy of this release to the social worker or social service designee at the hospital or ICF/MR.

If the person or guardian makes the referral directly to the Community Service Provider (CSP), the CSP must refer the person to their CDDO. At that time, the CDDO will follow the steps in 2.b. above.

### 3. Referral as a Result of ICF/MR Closure

Please refer to the Community Supports and Services Policy, “Voluntary Closure or Conversion of ICF/MR Facilities or Decertification of ICF/MR Beds,” approved December 4, 2001, revised April 1, 2009.

#### B. Visits to the Facility where the Person Resides and Visits to the Potential Community Service Provider

After the CDDO referral is made and a CSP is chosen by the person or the guardian, the CSP of choice will send a team or representative, including a case manager, if one has been chosen, to visit the person residing in the hospital or ICF/MR. This is the first step in getting to know the person. Additional visits will include going to the CSP location. These visits will involve the current team individuals supporting the person and the CSP representatives or their designees. The person or guardian will be consulted regarding the dates and times of these visits so they can be involved if they choose.

It is the responsibility of the CSP to ensure that a Person Centered Support Plan (PCSP) is developed and in place prior to the person moving into the community. Copies of the PCSP will be provided to the person, the person’s support network, ICF/MR, and CDDO. It is the CDDO’s responsibility to ensure that this plan is carried out and that the ICF/MR and CSP cooperate so that a timely transition occurs that meets the needs of the person to be successful in the community.

#### ***Choosing a Targeted Case Manager***

The Targeted Case Manager (TCM) is the person’s primary advocate and coordinator in the successful transition to community living. It is important that the person and their support network have a TCM they trust to effectively assist the person and be responsive to their needs.

In many areas of the state, there are multiple TCM providers from which to choose. The person has the right to choose their own TCM and to make changes if the current TCM is not meeting their needs.

The following are some considerations when initially choosing a TCM:

- Location

Where is the TCM based? Are they readily available in a crisis situation? Can they visit the person frequently if necessary?

- Specialty Area

Some TCM's "specialize" and have developed unique skills and talents working with individuals with unique support needs. Does the TCM have prior experience in helping individuals transition to the community from an institutional setting? Does the TCM have demonstrated knowledge of the person's disability, medical and support needs? Does the TCM have knowledge of community resources and how to access them?

- Size of Agency

Some TCM's work for large providers, some for small providers and others are independent or self-employed. There are benefits to each situation. What capacity does the agency have to provide alternative support in the TCM's absence? Is the TCM empowered to be a true advocate for the person as well as coordinator of services? Is the TCM able to think and work "outside the box" in developing unique living and support situations?

The CDDO will present the person and their guardian with a list of TCM providers in their region. They will assist the person in contacting agencies in order to meet and compare potential TCM. Some people will choose to meet with several agencies before they make a choice. Once a choice is made, the CDDO is notified and the TCM will begin the process of providing services to the person.

### **Changing Targeted Case Managers**

Anytime the person wants to change their TCM, they have the right to do so. If they are dissatisfied with the response to their request, they should contact the CDDO who will insure that their right to choose is respected. The appropriate personnel must be notified of the change in order to maintain the accuracy of BASIS information.

# Targeted Case Manager



### Section III. Targeted Case Manager

The Targeted Case Manager (TCM) is an individual chosen by the person and his/her family/guardian to be a coordinator of services and the person's primary advocate (refer to the [TCM manual](#)). The TCM is involved in all aspects of the person's life, both during pre-placement planning and once community services have begun. Therefore, the TCM has a fundamental responsibility to ensure the person is provided with opportunities to experience a variety of choices with minimal risk. As the coordinator of services, the TCM interacts with a variety of people who make up the person's network of support: family, friends, neighbors, and support staff. It is critical for the TCM to assist all members of the network of support to understand how they can help the person to evaluate risks in the choice-making process. In addition, the TCM must be objective and committed to the choices and opinions of the person.

**The following information has been taken from the Targeted Case Management training in the in 2008 and can be superseded per policy changes.**

*TCM services are defined as those services which will assist the person or his/her guardian in gaining access to medical, social, educational, and other needed services. Targeted case management includes any or all of the following services:*

*Assessment of a person or his /her guardian to determine service needs by:*

- *Taking the person's history*
- *Identifying the person's needs and completing the related documentation*
- *Gathering information, if necessary, from other sources such as family members, medical \ providers, social workers, and educators, to form a complete assessment of the person.*

*Development of a specific support/care plan that:*

- *Is based on the information collected through the assessment*
- *Specifies the goals and actions to address the medical, social, educational, and other service needs of the person.*
- *Includes activities that ensure the active participation of the, person and working with the person or his/her guardian and others to develop such goals and identify a course of action to respond to the assessed needs of the person.*

*Referral and related activities:*

- *To assist a person in obtaining needed services, including activities that help link the person with medical, social, educational providers, or other programs and services that are capable of providing needed services, such as referrals to providers for needed services and scheduling appointments for the person.*

*Monitoring and follow-up activities, including:*

- *Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the person's needs, which may be with the person, family members, providers, or other entities and conducted as frequently as necessary to determine whether:*

- *Services are being furnished in accordance with the person's care plan.*
- *The services in the care plan are adequate.*
- *There are changes in the needs or status of the person and, if so, making necessary adjustments in the care plan and service arrangements with the providers.*

The TCM is primarily responsible to facilitate the Person Centered Support Plan (PCSP) process. It will also be the responsibility of the TCM to “write” the plan in such a way that it can be understood and consistently implemented.

## Developing a Person Centered Support Plan



## Section IV. Developing a Person Centered Support Plan

The Person Centered Support Plan (PCSP) is typically facilitated by the TCM. The PCSP provides the foundation for the provision of services designed to support each person in achieving the lifestyle of their choice. The PCSP is designed to put choice fully in the hands of the person receiving services so that the supports meet their needs.

*The following are steps required to develop a quality PCSP:*

### A. Develop a Person-Centered Support Planning Team

The TCM helps the person identify the members of their family, the community, SMRH staff, CSP staff (if known) and other individuals that the person wants to be involved in the development of the PCSP. Anyone who makes a *positive* contribution toward building an effective plan can be involved. An initial brainstorming meeting may be necessary to explore options.

A successful brainstorming session will contribute to the major components of the support plan, and a higher comfort level among those who know and care about the person.

### B. Develop a Plan Around the Person (Don't Make the Person Develop Around the Plan)

A PCSP reflects the person's needs and lifestyle choices. A person who has a plan built around their wishes and that respects their hopes, dreams and fears is much more likely to be successful in the community. When the person is supported in creating the life they choose, they will require fewer supports. For those who have trouble expressing their hopes and desires, it is still possible to work with the person and those who know them to develop a plan that works best for that person. The team has the responsibility to do whatever is necessary to assist the person in making fully *informed* decisions.

Family member guardians who unreasonably obstruct the quality of life for a person may be referred to the court for re-evaluation/review of guardianship.

The Kansas Guardianship Program guardians who unreasonably obstruct the quality of life for a person may be brought to the attention of the Kansas Guardianship Program staff and discussed prior to requesting a court reevaluation/review

### C. Take All the Time You Need to Develop a Quality PCSP

The purpose of the PCSP meeting is to provide the CSP staff with the specifics of the person's preferred lifestyle, needs, and the supports necessary to assist the person in successfully living a quality life in the community. A PCSP cannot be developed in a one hour meeting, especially when a person moves to the community from an institutional setting. It will take several meetings, time and patience to develop a good plan and even longer to find a place for the person to live that meets their needs as spelled out in the PCSP.



*A quality PCSP contains the following:*

Introduction- The introduction of the PCSP should provide a brief history of the individual with enough detail included to sufficiently and objectively educate others about the person. This is true as well for the rest of the PCSP; it must be detailed enough to enable consistent supports and services to be delivered by staff or family unfamiliar with the person.

How the person makes choices- The PCSP should describe how the person communicates choices, how they prefer choices to be offered to them, and their understanding of the choices available to them. Provide details regarding the person's communication style. Is it verbal, through gestures, behavioral, or by means specific to the person which may include the use of assistive technology? All reasonable efforts must be made to realize the person's lifestyle preferences. If a person's preference is not currently available due to personal finances or other extenuating circumstances, then next best options must be pursued.

Risk Assessment and positive behavior support plan (if necessary)- If there is imminent, significant danger to health, safety or welfare, risk assessment must be completed, including a review of less restrictive alternatives tried and found not to be successful. After the risk assessment, the team must look at the need to provide positive behavioral supports. If those supports are not adequate to address the risk, then limiting choice may be considered. If choices are limited or restricted, the provider must have the positive behavior support plan reviewed and approved by CSP's Behavior Management Committee (aka-Human Right Committee) with informed consent from the person or their parents/guardian.

#### Preferred Lifestyle Choices

- *Where the person wants to live*- The specific location or type of setting in which the person wishes to live and a description of the services necessary for the person to be supported in that setting. If the person is living where they do not choose to live due to the person's financial limitations, the plan should note how the person will be supported to meet his/her preferred lifestyle in that setting, and note efforts that are being made to help the person make progress toward the preferred settings (see next best options).

➤ *The PCSP should describe the general characteristics of where the person is going to live:*

- Type of home (family home, apartment, own home)
- Features of the home(number of bedrooms, fenced or open yard, levels, stairs, size of halls and doorways)
- General location (what town or area, many or few neighbors, proximity to favorite stores or activities)
- Roommates (number and characteristics, smoking, non-smoking, common interests, gender, pets)
- How roommates will be chosen
- Necessary home modifications
- How living expenses will be covered

- *Where the person wants to work* - What the person would like to do for employment, or valued activity, the supports necessary for this to happen and some assessment of a person's strengths as related to employment. If the person is not working where he/she would like to, document the person's ongoing progress toward obtaining desired employment. If the person is involved in a day activity, the person's choice of activities will be documented, along with the supports needed for this to happen and notes of ongoing progress toward reaching goals for these activities if they are not immediately available.
- The PCSP should describe the general characteristics of where and how the person will spend a typical day away from his/her home:
  - a) Type of work, valued activities, or school and the supports necessary for this to happen and notes of on-going progress toward reaching goals for these activities if they are not immediately available.
  - b) Setting (i.e. with other disabled individuals, or integrated with non-disabled individuals).
  - c) Personal satisfaction/sense of value to be achieved from participating in a valued activity related to the Preferred Lifestyle Plan (PLP) (i.e., wages earned, volunteer work).
- *What the person wants to do for leisure*- This includes what, where and how a person will be able to participate in preferred recreational, leisure, and spiritual activities of his/her choosing.
- The activities the person likes to do for fun, the things he/she enjoys doing in and out of the home, and the supports necessary to get these done. If a chosen activity is not available, document why, and what progress is being made toward reaching these goals.
- Specific schedules should also be written into the plan. For example: First Baptist Church every Sunday at 8:00 am; Self-Advocacy Group first Monday of the month, 7:00 pm. The PCSP details for providers what ~~they~~ need to **be done** to support the person's choices (i.e. staff and transportation). Preferred contacts with family and friends and how these need to be facilitated and supported should also be documented.

Natural and Community Supports- The supports a person will be able to access in the community may include church, community classes, YMCA, a gym, the library, etc. The goal of these supports, along with meeting the person's leisure needs, is for the person to develop natural ties to the community. How will the person be supported in maintaining current valued relationships with friends, family, and in developing new relationships? How and by what means will the person be able to gain a sense of value and belonging within the community? What are the direct care staff characteristics that would be most successful in supporting the person in the community? Describe the type and extent of supports that will be provided by family members, friends, community members or other generic community supports, such as elder services, adult day care, etc.

Other Supports (assistive technology, etc.)- This includes a list of all other supports needed by

the person (such as assistive technology, type of staff he/she works best with, etc.) to be successful in the community. Also, any specialized training needed by staff needs to be listed here.

- Describe the type and amount of direct service support the person will be provided and describe how the direct service staff time will be shared with others in each setting. If a certain amount of one-on-one staff time with a person is necessary, describe the amount of time and when it will be used.
- Describe how basic health services, such as physician's visits, will be accessed. Indicate who will likely provide these services and how payment of these services will be made.
- Describe the type, amount, and duration of consultation and/or services provided by professionals such as nurses, speech therapists, occupational therapists, physical therapists etc. If possible, estimate the number of hours expected to be utilized per year.
- Describe how the recommendations of medical and therapeutic professionals are going to be carried out by direct service staff as part of the normal rhythm of the day (i.e. physical therapies, medication administration).
- Describe what modifications and/or equipment will be needed in the settings to achieve the person's desired lifestyle, such as: home modifications, wheelchairs, walkers, shower/bath equipment, ambulation aids, adaptive chairs, eating devices, clothing, and augmented communication devices.

The above is not an all-inclusive list. There are many different methodologies for developing a PCSP. The key is to understand that the PCSP is the document which guides the provision of services and supports the individual's needs to achieve his/her lifestyle preferences.

The plan may be written in a narrative format. The PCSP should be sufficiently detailed to assure the individual, and those who know and care about him/her, that the Community Service Provider (CSP) can support the individual's lifestyle. The plan may include several different types of documents attached to the PCSP to provide additional information.

Once completed, the PCSP should be distributed to all team members, as well as the local CDDO. (Contact your local CDDO regarding who is responsible for submitting this to SRS/DBHS/CSS.)

## Transition & Accountability



## Section V. Transition and Accountability

Transition refers to the process all persons experience when moving from a state hospital, or private ICF/MR to a Community Service Provider (CSP) under Home Community Based Services (HCBS).

Planning for living in the community involves many details which must be addressed *before* the person moves to his/her new home. The community service provider must consider, prepare and plan to assure all services and supports are in place before the person moves to the community.

The transition plan is typically included in the person-centered planning document and must be reviewed by the Regional Field Staff- Performance Improvement (PI) prior to transition.

A. Before approval of the transition plan consider/address the following items:

*“If the individual is accessing MFP demonstration project funds review the specific guidelines required for that project”.*

1. The SMRH or ICF/MR will obtain a signed authorization(s) for release of information from the individual and or guardian in order to share documents such as the PCSP, Plans of Care (POCs) BASIS, information, etc., with potential or selected providers.
2. Is the plan for the living arrangement affordable for the person? The individual and or guardian with the CSP should:
  - a. Estimate the personal costs for room, board, utilities, etc.
  - b. Have all appropriate community resources been explored to assist the person afford his /her chosen living arrangement or in a short time obtain their chosen living arrangement (section 8, (HUD)etc.)?
  - c. If the person still cannot afford the living arrangement, what is the next best option in order for the person to afford to live in the community?
3. Is the person receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? The TCM must ensure that the SSI or SSDI is in place and receiving full benefits prior to move.
  - a. Is there a need for a Social Security Representative payee?
  - b. Does the individual have a payee and if so who is it?
  - c. Does the individual or his/her payee understand the Social Security benefits may increase upon movement to the community, and that a standard practice is to use these benefits to meet room and board expenses?
4. The individual’s TCM should apply for food stamps immediately after the individual moves to the community. The TCM should communicate with the

individual and or guardian and service provider how much benefit the he/she will receive.

5. The TCM is also responsible for securing other benefits such as housing assistance, medical card, etc., immediately after the individual moves to the community. This is an ongoing process.

6. The service provider is responsible for requesting start up funds.

B. Once the transition plan is approved by the SMRH and check on this SRS/DBHS/CSS staff, the following items must be addressed. NOTE: Always include the individual, his/her guardian and TCM in the decision making process.

- SMRH or ICF/MR will arrange a community visit to include the community provider.
- Agency will review housing options with the individual and or guardian.
- TCM will communicate with the Economic and Employment Support (EES) Specialist at the local SRS office to arrange for the transfer of the Medicaid case and to ensure proper coding for HCBS/MRDD. If the individual is using MFP demonstration project funds the proper coding would be MF/MRDD.
- The individual's TCM, guardian and other members of the support team will meet to discuss what the individual owns, what he/she needs, how to obtain needed items, etc., when he/she move.
- TCM will develop a PCSP for the individual prior to moving to the community and will train staff on he/she's PCSP including transition information and positive behavior support plan, etc.
- TCM will complete the POC for the individual moving.

C. Refer to the [Targeted Case Management Training Manual](#) for more specific information about benefits and available services.

## Ongoing Monitoring & Review



## **Section VI. Ongoing Monitoring and Review**

The goal of ongoing monitoring and review is to ensure the individual; is successful in the community and to ensure the individual does not return to an institutional setting. Transition is an ongoing process that requires continuous monitoring and follow-up. The following steps are necessary components toward assuring a successful transition.

All Federal MFP participants will be asked to participate in a Quality of Life survey that must be administered 3 times in the life of each participant: 1<sup>st</sup> survey- prior to transition from ICF/MR, 2<sup>nd</sup> survey-during their 365 days in the MFP program, 3<sup>rd</sup> survey-in the following year when they are an HCBS participant. In addition all MFP participants will receive an SRS Quality Assurance review during their year in the MFP project.

- A. The following services to support ongoing monitoring and review are available during the transition period from the State Mental Retardation Hospital (SMRH).
  - 1. Consultation and staff assistance to the Community Service Provider (CSP) to make the transition period smoother, such as staff training and positive behavioral support planning.
  - 2. Providing ongoing consultation during significant life events or crises.
  - 3. Provide out-patient services (such as) dental care, wheelchair repair, occupational therapy, physical therapy, psychological evaluations, and speech language/communication evaluation.
- B. The TCM will convene a meeting of the individual's chosen support network to review the Person Centered Support Plan, the positive behavioral plan and the ongoing success of the transition.
  - 1. Unless otherwise needed or requested the meeting should be held between 30 and 90 days after the individual moves into the community.
  - 2. This follow-up meeting will address the following:
    - a. Does the initial person-centered support plan adequately address the individual's support needs? What changes need to be made to assure success?
    - b. Are the supports outlined in the plan consistent with the individual's lifestyle preferences? What changes need to be made to facilitate movement toward the individual's lifestyle preferences?
    - c. What additional training needs to be completed for staff and community members in order for the individual to continue to be successful in the community?



- d. What, if any, changes should be made in the cost proposal?
- C. The CDDO Quality Assurance Committee is also responsible to monitor success and assure that the transition plan and the PCSP are followed and that the individual is receiving quality services.
- D. If an individual is not successful in the community the responsibility lies with the support team and not the individual. Successful transition planning must include a clear understanding of the individual's support needs and the ability to change or alter the plan as roadblocks to success occur. The support team must alter their strategies, teaching methods, and support systems to meet the needs and learning style of the person. Return to an institutional setting is not an option unless all alternatives for success in the community have been exhausted.

# APPENDICES

## I. Definitions

## II. Resource List & Links

### ***Appendix I. CLC Manual Definitions***

Approved referral process- Refers to the process defined in the current fiscal year's CDDO contract with SRS/HCP/CSS.

Basic Assessment and Services Information System (BASIS)- a computerized program developed to collect comprehensive information about persons with developmental disabilities, and to provide more timely funding eligibility determinations for individuals in the DD system in Kansas.

Best practices- on-going practices regarding to delivering, obtaining, and improving services and supports for people with disabilities. Best practices are never static and continue to need work for improvement and change.

Capacity building- refers to the process of stabilizing, improving, and/or expanding the ability of the community to provide responsive, quality supports and services to community members with developmental disabilities. The purpose of capacity building is to build systems of networks that are responsive, flexible, and grow to meet the needs of the entire community.

Community Developmental Disability Organization (CDDO) - Each community mental retardation center organized pursuant to the provisions of K.S.A. 19-4001, et. seq., currently established and operating as of the effective date of this regulation shall be recognized as a CDDO. The CDDO shall have the same service area that the Community Mental Retardation Center (CMHC) was previously recognized for.

CDDO Quality Assurance- each contracting CDDO shall ensure the quality of the services being provided to persons being served by the CDDO or by an affiliate. Ensuring quality shall include providing for on-site monitoring by a local committee made up of persons served, their families, guardians, interested citizens, and providers.

Community Living Choices (CLC) - Previously known as the Community Integration Project (CIP) initiated in 1991 to transfer of individuals from SMRHs to community services. The vision of the CIP program was for Kansans with developmental disabilities to live, work, play and learn in a natural, inclusionary setting. The vision also included the philosophy that these individuals would direct their own individual plans of care, be supported in the context of their family and friends, all while insuring that the plan respected their individual lifestyles and cultural differences.

Community Mental Retardation Centers (CMRC) - previous name for organizations we now know as Community Developmental Disability Organizations (CDDOs).

Community residential setting- a non-institutional setting that provides assistance, acquisition, retention and/or improvement in skills related to activities of daily living, such as: personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills.

Community Service Provider (CSP) - an organization that affiliates with a CDDO to provide direct services to consumers. Some CDDOs also operate as CSPs. Some CSPs only carry a limited license and can serve no more than two individuals.

Day activity (or day service)- regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve as vehicles to maintain or increase adaptive capabilities, independence or integration and participation in the community.

Developmental disability (DD)- defined in the DD Reform Act as “Mental Retardation (substantial limitations in present functioning that is manifested during the period from birth to age 18 years and is characterized by significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior including related limitations in two or more of the following applicable adaptive skill areas: Communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work).”

Developmental Disability (DD) Reform Act- In 1995, the Developmental Disabilities Reform Act became law in Kansas. Through this Act, the state redefined its policy to assist persons who have a developmental disability. The provisions of this act are delineated in Kansas Statutes Annotated (K.S.A.) 39-1801 through 39-1810.

Essential Lifestyle Plan (ELP) - previous document that aided in the transition of a person to the community—a form of person centered planning in which the individual is the focal point of the planning and who themselves shape the entire process based on their own goals and choices.

Extraordinary funding- (requires cost proposal, see [Persons Exiting Institutional Settings](#)) when the person’s served needs require monies above the regular tier rate reimbursement. The person may access extraordinary funding via special tiers or individualized rates.

Gatekeeping- each request for admission to an ICF/MR or state institution shall be submitted to the CDDO responsible for the county in which the person is currently residing. The CDDO shall implement a procedure to review each request for admission to an ICF/MR or state institution. (See K.A.R. 30-64-29.)

Generic community supports- services available to all person in the community, such as: physicians, dentists, other medical professionals, pharmacies, senior centers, community centers, grocery stores, mental health centers, transportation services, criminal justice victim assistance, legal services, domestic violence centers, support groups, etc.

HCBS/MRDD waiver- a Medicaid program for individuals who are five years of age or older, who are mentally retarded or otherwise developmentally disabled, who meet the criteria for

ICF/MR level of care as determined by ICF/MR (HCBS/MRDD) screening, and who choose to receive HCBS/MRDD services rather than ICF/MR services.

Home and Community Based Services (HCBS)- services provided in accordance with a federally approved waiver to the Kansas Medicaid State Plan which are designed to prevent unnecessary use of institutional services at a cost no higher than that of institutional care. -

Individualized tier rate- a rate calculated specific to the person's served needs. Individualized rates are audited to cost and designed to support persons with extensive service needs.

Informed choice- at the act of selecting an alternative, based upon understandable substantive information about available options.

Intermediate Care Facility for persons with Mental Retardation (ICF/MR)- a facility that provides twenty-four hour supervision and training for persons with mental retardation or related conditions and is regulated through requirements established by Medicaid.

Kansas Administrative Regulation (K.A.R.) - Official state regulations as are documented in the Kansas Register. Kansas statutes (laws) have provided for legislative oversight of rules and regulations filed by state officers, boards, departments, and commissions. All rules and regulations of a statewide character filed in the office of the revisor of statutes remain in force until and unless the legislature disapproved or rejected the regulations. The law charges the 12member joint committee on administrative rules and regulations to review all proposed rules and regulations during the 60-day public comment period prior to the required public hearing on the proposals (includes forms used by agencies which are excluded from the definition of rules and regulations).

Kansas Living Outcomes, Second Edition (KLO2) - A quality assurance tool used by Social and Rehabilitation Services (SRS) for individualized and comprehensive surveys of persons receiving services. This tool assists in determining the level to which outcomes related to licensing standards and responsiveness to personal needs/lifestyle preferences are present in the lives of persons served.

Kansas Guardianship Program (KGP) - is an organization that locates and trains volunteers to be the guardians of individuals that have been adjudicated by the court as needing a guardian.

Lifestyle preferences- are documented in the PCSP/PCP; they include such things as where the person wants to live, with whom the person wants to live, what work or other valued activity the person wants to do, with whom the person wants to socialize, and, in what social, leisure, religious or other activities the person wants to participate.

Limiting choice- anytime a provider limits a person's right to make their own choices, that provider is imposing a restriction on the person. The use of psychotropic or other types of medications used to manage behavior is also a restrictive intervention (see K.A.R. 30-63-23).

Mental Retardation (MR) - the Medicaid definition of conditions related to mental retardation

means a severe chronic disability which requires treatment or services similar to those for persons with mental retardation. Defined by the State of Kansas as significantly sub-average intellectual functioning which: 1) is manifested before the age 22; and 2) is evidenced by: a) A score of 70 or below on any standardized measure of intelligence; and b) concurrently existing deficits in adaptive behavior. Also see Developmental Disabilities definition.

Money Follows the Person Demonstration Project (MFP) – MFP provides an additional opportunity, via a 5 year federal grant, to support individuals who desire to move from ICF/MR settings to community based settings. Individuals must have resided at the ICF/MR for 6 continuous months. The demonstration project allows for 365 days of demo services that mirror MR/DD waiver services and assures access to HCBS funds at the end of the demonstration project. New participants can enroll in MFP through June 30, 2011, unless the demonstration project is extended.

Natural supports- non-paid supports such as family, friends, neighbors, co-workers, faith-based organizations, etc.

Next best options- Alternatives that are develop if the preferred lifestyle cannot be met due to financial or other issues. They are based on the values driving the person's choices, the related needs, and an expansive consideration and potential alternatives which will honor the core values.

Person Centered Support Plan (PCSP) or Person Centered Plan (PCP) - document outlining the goals for service provision that focuses on the consumer's wants and needs.

Person centered support planning process- the process by which the support team members chosen by the person (i.e., family/guardians, service providers, and other individuals important to the person) plan for and secure supports and services necessary for the person to live the life of their choosing and to ensure success in the community.

Plan of care (POC) - a document which delineates which service providers and/or natural supports will assist the consumer, what services will be provided, the frequency of the service and its' cost. (i.e. details home and community based services to be provided to persons served).

Portability- when a person moves from one service area to another and wants to continue receiving community services, the level of state and federal financial support utilized to provide services and supports for that person is transferred to the person's new service area.

Positive behavioral support plan- the Person Centered Support Plan is the starting point and the foundation for a positive behavioral support plan, which is developed for people with developmental disabilities who engage in serious problematic behaviors. Positive behavior support plans encourage a person to learn and retain lasting behavior change. The focus changes from "managing" the behavior to "understanding the person and the function the behavior serves for the person." A lifestyle change occurs because positive behavior supports are grounded in person-centered values that respect the dignity, preferences, and dreams of each person.

Preferred Lifestyle Plan (PLP)- also known as an Essential Lifestyle Plan (ELP), Individual Program Plan (IPP), or QLP (Quality Lifestyle Plan), this document is developed by a CSP in consultation with, and approved in writing by, the person and the person's legal guardian, if one has been appointed and should include the following: where the person wants to live, with whom the person wants to live, what work or other valued activity the person wants to do, with whom the person wants to socialize, and in what social, leisure, religious or other activities the person wants to participate.

Quality assurance- The HCBS/MRDD waiver requires the state to evaluate the effectiveness of its HCBS programs to ensure that the services provided meet the needs of the consumer; that the consumer's basic health and safety are protected; and that consumers who receive these services meet the level of care criteria..

Quality [Performance] Improvement- The performance of discovery, remediation and quality improvement activities in order to ascertain whether the waiver meets the assurances, correct shortcomings, and pursue opportunities for improvement. Quality [Performance] Improvement also is employed to address other areas of waiver improvement.

Release of information- a signed document that allows an organization or individual (such as a doctor) to obtain specific, confidential information about another person. The specific information being requested should be delineated on the release form. A release of information form can be revoked at any time by the party who has signed the release (be it the individual or their guardian).

Risk assessment- assists individuals served and their guardians in understanding negative consequences of known choices the individual might make and which may involve risk to that individual.

Risk- Eminent, significant danger to the person's health, safety, or welfare.

Self Determination- refers to controlling the basic things in one's life such as other's respecting your feelings, choices, preferences and behaviors. It is something all people have a right to regardless of age or ability. Self Determination is closely linked with how people view themselves, how others view the person and a person's general quality of life. All people with developmental disabilities and other related conditions should be afforded the opportunity to live a self-determined life.

Service delivery system- the network of state, federal, and community social programs and services that are provided to people with disabilities to support them in their preferred lifestyle.

Single point of entry (or application)- Each contracting CDDO shall develop and implement a means by which the CDDO shall become the single point of application, eligibility determination, and referral for persons desiring to receive community services within the service area of that CDDO. (See K.A.R. 30-64-23).

Social Security representative payee- A representative payee is an individual or organization that

receives Social Security and/or SSI payments for someone who cannot manage or direct the management of his/her money. Payees should use the funds for the current and foreseeable needs of the beneficiary and save any remaining funds for the beneficiary's future use.

Special tier rate- special tier rates may be requested for persons who need increased staff support beyond that provided within the regular tier rates.

SRS/DBHS/CSS- an acronym for the State of Kansas Department of Social and Rehabilitation Services, Division of Disability and Behavioral Health Services, Community Supports & Services.

Start-up funds- the monies (when available) allocated to a person to help defray costs associated with moving to the community.

State Mental Retardation Hospital (SMRH)- also considered and certified as a *public* ICFs/MR, there are two SMRHs in Kansas: Parsons State Hospital and Training Center, and the Kansas Neurological Institute.

Statewide (CDDO) Funding Committee- set up through the FY 2002 SRS/CDDO contract, the Committee's goal is efficient management of the statewide allocation in order to maximize the system's financial ability to meet the needs of eligible Kansans with developmental disabilities. The Committee's two responsibilities are to recommend adjustments in CDDO allocations and annually review the allocation methodology.

Support network- One or more individuals selected by a person or by the person and the guardian, if one has been appointed, to provide assistance and guidance to that person in understanding issues, making plans for the future, or making complex decisions. Such individuals share a personal relationship with the person such that they are considered central to or interested parties to the planning of community services and supports for that person.

Targeted Case Management- Targeted Case Management services are services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Targeted Case Management may include: assessment of an eligible individual to determine services needs; development of a specific care plan; referral and related activities; monitoring and follow-up activities. Targeted Case Management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

Teaching family model home- addresses and modifies behavior for persons served who may lack the appropriate social skills to experience success in a regular, less-restrictive setting. It is used to reinforce positive behaviors by immediately teaching how to correct negative behaviors and to focus on appropriate alternative skills.

Tier rate- reimbursement for HCBS/MRDD waiver services in which the rate increases as the person with the disability's level of need increases.

Wellness monitoring- a process whereby a registered nurse evaluates the level of wellness of a consumer to determine if the consumer is properly using medical health services as recommended by a physician and if the health of the consumer is sufficient to maintain him/her in his/her place of residence without more frequent skilled nursing intervention.



## ***Appendix II. Reference List***

### **State Hospital Contacts:**

Parsons State Hospital & Training Center  
2601 Gabriel, P.O. Box 738  
Parsons, KS. 67357  
620-421-6550  
<http://www.pshtc.org/>

Kansas Neurological Institute  
3107 West 21<sup>st</sup> Street  
Topeka, KS 66604  
785-296-5301  
<http://srsnet.srs.ks.gov/hospitals/kni/Default.htm>

**The following resources are available Community Supports & Services (CSS) web link:**  
<http://www.srskansas.org/hcp/cssindex.htm>

- BASIS Manual
- Targeted Case Management Training Manual
- SRS/DBHS/CSS Policies
- DD Handbook
- Current CDDO & CSP Contact Information
- Current Private ICF/MR Contact Information
- Regional Quality Assurance and Performance Improvement Contact Information
- Persons Exiting Institutional Settings & Forms

**Kansas Legislature Statue Search:** <http://www.kslegislature.org/legsrv-legisportal/index.do>

- Guardianship Disputes (K.S.A 74-9601, 74-9606, etc. seq.)